STATE VETERANS HOME PLAN OF CORRECTION -

DATE OF INSPECTION: June 2-6, 2008

STANDARD		DEFICIENCY	PLAN OF CORRECTIVE ACTION	SVH STAFF	EVIDENCE OF IMPROVEMENT	VA STAFF SIGNATURE	DATE	METHOD OF REVIEW
§ 51.70 Resident Rights e. 1.	Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Residents have a right to personal privacy in their accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. This does not require the facility management to give a private room to each resident.	This was not met as evidenced by member # 14 in the bath house on 2nd Phillips having privacy ignored with numerous individuals walking into bath house during the bathing process. The maintenance man was in putting in an alarm, another member was toileting himself when Member #14 was brought in. Other staff members also came in during the bathing process.	1. Larger signs will be made and posted on shower room doors to assure other members and staff do not enter the area when bathing is in progress by 07/18/08. 2. All staff were educated to be alert for the large DO NOT ENTER BATHING IN PROGRESS signs on the shower room door and on Member right to Privacy by 07/18/08. 3. Members were educated on right to privacy and DO NOT ENTER BATHING IN PROGRESS sign and what that means at Member Council on 07/02/08. 4. Unit Director or designee will monitor for privacy compliance daily M-F x 3 weeks then quarterly x2. Results of the monitoring will be analyzed and taken to QA for review and revision. To be completed by 08/11/08.	1. Susan Peterson NE, Jerry Peterson Maintenance Supr. 2. Susan Peterson NE 3. Dave Kreutzer DSW 4. Susan Peterson NE				
§ 51.70 Resident Rights f.2	Grievances. A resident has the right to: Prompt efforts by the facility to resolve grievances the resident may have, including	This was not met as evidenced by review of the Grievance files and meeting with member council. In review of the files there is good documentation of addressing concerns, however, there is a lack of documentation indicating	1. The Director of Social Work will revise the policy and forms for investigating and responding to member grievances to clearly show the reporting party was communicated the	1. Dave Kreutzer DSW				

STANDARD	DEFICIENCY	PLAN OF CORRECTIVE ACTION	SVH STAFF	EVIDENCE OF IMPROVEMENT	VA STAFF SIGNATURE	DATE	METHOD OF REVIEW
those with respect to the behavior of other residents.	that the individual who had originated the concern had been asked if the issue was resolved, or at least acknowledged that it had been addressed. During a meeting with the member council they initiated comments indicating that they were not gotten back to with "answers to their individual complaints." The members indicated they did not know whether the concerns were resolved or not.	resolution and the party's response to the resolution by 07/15/08. 2. The Director of Social work will follow up ALL member Problem ID's received each month, by interviewing the reporting party and assessing that the reporting party was informed of the investigation/resolution, and given an opportunity to provide feedback on the resolution. Report will be given to QA monthly. Start 07/01/08.	2. Dave Kreutzer DSW				
§ 51.80 Admission, transfer and discharge rights. a.4.1	Transfer and discharge: Notice before transfer. Before a facility transfers or discharges a resident, the facility must: Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand	This was not met as evidenced by the State Veterans Home not having a written notice to give to members being transferred.	1. Policy was reviewed and revised by 07/18/08. 2. All transfers and discharges will be reviewed monthly X3 and assure that written documentation of right to appeal was given to the appropriate person. This will be completed by HIM or designee. Results of this review will be analyzed and taken to QA for review or revision. By 08/11/08.	1. Susan Peterson NE 2. Cindy Urwiller, HIM Mgr.				
Contents of the	This was not met as						

STANDARD		DEFICIENCY	PLAN OF CORRECTIVE ACTION	SVH STAFF	EVIDENCE OF IMPROVEMENT	VA STAFF SIGNATURE	DATE	METHOD OF REVIEW
a.6.i.ii.iii .iv.v	notice. The written notice specified in paragraph (a)(4) of this section must include the following: The reason for transfer or discharge; The effective date of transfer or discharge; The location to which the resident is transferred or discharged; A statement that the resident has the right to appeal the action to the State official designated by the State; and The name, address and telephone number of the State long term care ombudsman.	evidenced by the State Veterans Home not having a written notice to give to members being transferred.	1. See POC for 51.80 Admission, transfer and discharge rights a.4.1	1. Susan Peterson NE				
§ 51.100 Quality of Life. a.	A facility management must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. Dignity. The facility management must promote care for residents in a manner and in an environment that maintains or	This is not met as evidenced by surveyor observation of residents being cared for in a manner that did not maintain their dignity. Staff member #17 was preparing resident # 34 for his whirlpool bath, his clothing was removed and no towel was placed for privacy over the peri area. The member was sitting in the bath chair with no clothes nor covering. This was all done in bath house and he was disrobed for a significant amount of time. Staff member # 11 was preparing Member #14 for his bath in his room. She	1. Staff members involved were educated on need to maintain privacy and dignity *Done 06/06/08. 2. All members were assessed with specific steps identified as to how to prepare each member for bathing, transfer to and from bathing room to maintain dignity, respect and privacy Done 07/11/08.	1. Susan Peterson NE 2. Susan Peterson NE				

STANDARD	DEFICIENCY	PLAN OF CORRECTIVE ACTION	SVH STAFF	EVIDENCE OF IMPROVEMENT	VA STAFF SIGNATURE	DATE	METHOD OF REVIEW
	enhances each resident's dignity and respect in full recognition of his or her individuality.	took off his shirt and transferred him to the sit/stand lift and then took off the remainder of his clothing and sat him down on bath chair. She then realized that she had nothing in room with which to cover him. Unit director went to find sheets to cover him. She came back in and covered him with the sheets. Resident's feet were flat on the floor and the bath aide was unable to push shower chair forward.. This member had no ability to lift or move feet independently. The bath aide turned the bath chair backwards and pulled resident in bath chair out of room and down the hall towards bath house backwards.	3. GIVH will have a specific bath aide identified for each Unit by 07/18/08. Unit Director or designee will monitor bathing and transfer process to and from bathing 3X week x 4 weeks. Results of the monitoring will be analyzed and taken to QA for review and revision. Completion date 8/11/08.	3. Susan Peterson NE				
§ 51.100 Quality of Life. i. 2	Environment. The facility management must provide: Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	This was not met as evidenced by on initial tour… Anderson buildinig - janitor closets unlocked one with key hanging in lock, chemical throughout unit unlocked, bathing area utilized as storaged for commodes, shower chairs, laundry tubs and lifts making toilet not accessable for use , members care items setting around bath houses, storage of building power tools in unlocked area. 2nd Phillips Maintenace door unlocked. Nourishment area had chemicals unlocked under sink. 2nd WWII Muliple chemicals in an unlocked area in nurishment area. 2nd day In Anderson, janitor's	1. Housekeeping to provide an in-service to their current staff Completed by 7/18/08 New Employee Orientation Checklist revised. Audits of locked doors and chemical location completed weekly. Report to QA mtg. monthly. *Start 07/08/08. 2. Bathing areas cleaned and accessible to staff and members. Risk Management (RM) will complete a surveillance to assure this is done by 7/11/08 and will monitor with routine	1. Teri Engleman, Hskpg Supr. , Bonnie Harvey: Hskpg Supr. 2. Vicki Lepant IC/RM				

STANDARD	DEFICIENCY	PLAN OF CORRECTIVE ACTION	SVH STAFF	EVIDENCE OF IMPROVEMENT	VA STAFF SIGNATURE	DATE	METHOD OF REVIEW
		closet on east side unlocked.	infection control rounds & reported to the QA at least quarterly. 3. Maintenance Door unlocked on 2nd Phillips. The door lock will be changed to an automatic lock by 07/30/08. 4. Per Maintenance, HDQ boxes were secured on walls by 06/13/08. RM will complete a surveillance to assure this is done by 7/11/08. All chemicals removed from member rooms and areas 06/03/08. Ongoing monitoring will be done with routine Infection Control rounds and reported to the QA at least quarterly. 5. Power tools in member area on Anderson, immediately a lock was placed on the door to secure area. 06/02/08. 6. Child proof locks on 2WW Nourishment room in place 06/02/08. 2EP Unit Director to in-service staff on the need for keeping Nourishment doors locked when not in use. Will be	3. Jerry Peterson Maintenance Supr. 4. Jerry Peterson Maintenance, Vicki Lepant IC/RM 5. Jerry Peterson Maintenance Supr. 6. Jerry Peterson Maintenance Supr. Teri Engleman Hskp. Susan Peterson NE				

STANDARD	DEFICIENCY	PLAN OF CORRECTIVE ACTION	SVH STAFF	EVIDENCE OF IMPROVEMENT	VA STAFF SIGNATURE	DATE	METHOD OF REVIEW
		completed by 07/18/08 and reported to QA per signature sheet. Large 11 X 14 sign on door states 'Keep Door Locked when not in Use' Done 07/07/08.					
§ 51.110 Resident assessment. b.1	Comprehensive assessments. The facility management must make a comprehensive assessment of a resident's needs;	This was not met as evidenced by member #2 who had a stage II pressure ulcer at time of assessment and it was not marked on the MDS. He had a catheter that was not marked on MDS. A restorative ambulation program that was not marked and occupational therapy that was not marked. Member #13 uses a 4 wheel walker to ambulate and this was not marked on MDS. Pressure ulcer coded as an R and should be a II. Member #3 was on IV antibiotic and was not marked on section K5 on most recent MDS. Section G 1h eating score of 2 which means he needs assistance to eat and the score of 1 means all he needs is set up. These are contradictory. Member #23 on most recent MDS, there were two coding errors on ADLs which were locomotion off unit (was 4-2 and according to ADL flow sheet 0-0) and eating (was 0-1 and according ADL flow sheet 0-0). Member #23 on MDS with ARD of 2-20-08 there were two coding errors with regard to waking in corridor	1. Corrections were made to MDS for Member #12, #13, #3 and #23 by 07/07/08 2. Weekly educational meetings on RAI process are scheduled to begin with the MDS coordinators beginning 07/07/08. These meetings will be directed by the Interim Nurse Executive and will continue until formal training by NHCA in August 2008. A focus of the meeting will be on ADL accuracy. By 08/08/08. 3. MDSs will be audited weekly X4 for accuracy and then monthly x3. Interim Director or designee will analyze the results of the audits and take to QA for review and revision. Completed by 08/11/08.	1. Susan Peterson NE 2. Susan Peterson NE Dave Kreutzer, DSW Nancy Klimek, D-Rec Kathy Jensen, D-FS 3. Susan Peterson, NE Dave Kreutzer, DSW Nancy Klimek, D-Rec Kathy Jensen, D-FS				

STANDARD		DEFICIENCY	PLAN OF CORRECTIVE ACTION	SVH STAFF	EVIDENCE OF IMPROVEMENT	VA STAFF SIGNATURE	DATE	METHOD OF REVIEW
		and eating. Walk in corridor was scored 8-8 and according to ADL flow sheet was 4-2. Eating was scored 2-2 and according ADL sheet was 1-1. In review of 15 charts there were numerous errors with regards to ADL accuracy on the MDS.						
§ 51.110 Resident assessment. b.4	Use. The results of the assessment are used to develop, review, and revise the resident's individualized comprehensive plan of care, under paragraph (d) of this section.	This was not met as evidenced by triggered RAPS on MDS assessments were not always addressed on care plan .	1. Weekly educational meetings on RAI process are scheduled to begin 07/07/08 with formal education by NHCA ending 08/08/08. 2. All admission, annual and change of condition care plans will be audited to assure the triggered RAPS to be care planned are on the care plan. Interim Nurse Executive and/or designee will complete the audit and report to QA monthly. Completed by 08/11/08.	1. Susan Peterson, NE 2. Susan Peterson, NE Dave Kreutzer, DSW Nancy Klimek, D-Rec Kathy Jensen, D-FS				
§ 51.110 Resident assessment. d.1	Comprehensive care plans. The facility management must develop an individualized comprehensive care plan for each resident that includes measurable objectives and	This was not met as evidenced by Member # 13 triggered out for pain on quality indicator information and pain was not part of the resident's care plan. Member # 11 care plan indicated he was receiving OT which he is not.	1. Care plans were updated for Members #13 and #11. Done 07/11/08. 2. Education will be given to Care Plan Team Members by 07/31/08 regarding care plan process	1. Susan Peterson, NE Dave Kreutzer, DSW Nancy Klimek, D-Rec Kathy Jensen, D-FS 2. Susan Peterson, NE Dave Kreutzer, DSW Nancy Klimek, D-Rec Kathy Jensen, D-FS				

STANDARD		DEFICIENCY	PLAN OF CORRECTIVE ACTION	SVH STAFF	EVIDENCE OF IMPROVEMENT	VA STAFF SIGNATURE	DATE	METHOD OF REVIEW
	timetables to meet a resident's physical, mental, and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following:	In review of 31 care plans, surveyors found inaccuracies: medications listed were incorrect or not updated, care plans were not systematically formated to easily find interventions compromising functionality of care plan. Goals and problems difficult to determine in many instances. None current information documented on care plans i.e. CT scan of head 9-6-07, CT scan of neck 10-1-07, ENT appointment Omaha VA 10-10-07 (Member # 34). Inappropriately documented progress note material on care plan, i.e. member/family alerted of room change Member # 13) Numerous hand written notes not being identified as problem, goal, or intervention	and formulation of accurate and reasonable care plan. MDS coordinators will complete NHCA RAI process seminar MDS coordinator training by 08/08/08. 3. Social Work, Recreation, Dietary and Nursing Administration will audit weekly the care plans revised, in accordance with the MDS schedule. This review will continue until all of the members care plans have been reviewed and revised. The results of the audits will be taken to QA for review and revision. Process in place by 08/11/08.	3. Susan Peterson, NE Dave Kreutzer, DSW Nancy Klimek, D-Rec Kathy Jensen, D-FS				
§ 51.150 Physician services. b.3	Physician visits. The physician must: Sign and date all orders.	This is not met as evidenced by a stamp signature is being used on various forms. SVH policy states the provider will initial the stamped signature and this is not being done.	Signature stamp policy revised 07/10/08. Medical Director will monitor monthly through MRR committee and report to QA.	Medical~ Dr. King				

Did the SVH submit CAP within 10 days? _____Yes _____No

Approve / Disapprove

Full Certification Provisional Certification